TESTIMONY OF

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HEALTH CARE FINANCING ADMINISTRATION

ON MEDICARE REIMBURSEMENT
before the

HOUSE GOVERNMENT REFORM SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES FORT WAYNE, INDIANA

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Chairman Mica, Congressman Souder, thank you for inviting me to be here today with you to discuss the Health Care Financing Administration's (HCFA) efforts to improve Medicare guidance to hospitals and other providers, as well as recent changes in Medicare hospital payment policies. I am grateful for this opportunity to hear from you firsthand about your needs, concerns, and ideas.

HCFA is responsible for administering the Medicare program, which provides health insurance coverage to about 39 million Americans. The Medicare program provides coverage for hospital services in accordance with Medicare law, which is very prescriptive. HCFA issues regulations governing the program based on the law. And, also by law, HCFA contracts with private insurance companies, referred to as intermediaries or carriers. These companies are directly responsible for processing and paying claims to hospitals and other providers, in accordance with the regulations we have established and their own local medical review policies.

Assuring and enhancing access to quality health care for beneficiaries is a priority for HCFA. We are taking a number of pro-active steps to educate providers about Medicare payment policy and procedures, and to increase our oversight of the private insurance companies that process Medicare claims. We want to ensure that our guidance is clear, and that providers and our contractors understand Medicare rules and follow them appropriately. We also are increasing our efforts to identify fraud, waste, and abuse. In addition, we already have implemented over the majority of provisions in the Balanced Budget Act of 1997 (BBA). We are also implementing additional changes included in the Balanced Budget Refinement Act (BBRA), which became law late last year. The BBRA makes substantial investments to meet the needs of our nation's hospitals and their patients. The BBA changes, combined with efforts to fight fraud, waste, and abuse in the Medicare program, have helped extend the solvency of the Medicare Trust Fund until 2023.

Improving our Guidance and Education

The laws governing Medicare are complex and extensive. We recognize this and are increasing

our efforts to reach out to all providers to ensure that our guidance on Medicare policies, and that issued by our contractors, is clear and understandable. As part of this education effort, we have initiated a wide range of provider educational activities targeted specifically to hospitals. For example, we are:

- airing satellite broadcasts to hundreds of sites across the country on topics of interest to providers such as resident training, as well as women's health and adult immunization initiatives;

- surveying health care providers nationwide and analyzing data collected to develop new education strategies for reaching out to Medicare providers;

- developing computer-based training modules for providers on topics such as proper claims submission, Medicare Secondary Payer rules, and Medicare fraud and abuse efforts;

- writing articles on timely topics for fiscal intermediary bulletins and other publications targeted toward hospitals;

- maintaining the HCFA web site, www.hcfa.gov, to provide up-to-date, easily accessible material for hospitals on a wide variety of issues, including interactive courses on the proper filing and documentation of claims;

- communicating on a regular basis through conference calls with national and state hospital associations and mailings to hospitals nationwide on issues of interest;

- sharing feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims so we can reduce the number of improper claims among the vast majority of providers who make only honest errors; and,

- enhancing our toll-free customer service lines at all Medicare intermediaries to provide answers to questions hospitals and other providers may have or to discuss problems they encounter in dealing with Medicare.

As part of our enhanced provider education efforts, we are launching a multi-faceted education program to ensure that hospitals and their billing vendors have both the information and training needed to implement systems changes for the outpatient prospective payment system (PPS), which becomes operational July 1. As part of this effort, this May we will conduct "train-the-trainer" sessions for our Medicare fiscal intermediaries. Our intermediaries will, in turn, provide training to hospitals and their vendors. We will provide intermediaries with a comprehensive guide and two days of intensive in-person training. We are instructing all intermediaries to take steps to disseminate program information to providers as soon as possible. Intermediaries will post these instructions on their Internet websites as well as publish articles in provider bulletins and conduct other outreach efforts to get the message out to providers. In addition, we have invited representatives from national and state-level hospital associations to attend the training sessions in order to facilitate the timely exchange of information. We are also hosting a national satellite broadcast on June 1 so that all interested parties can learn about the new regulation.

Improving Oversight of Our Contractors

We are also taking steps to substantially strengthen oversight of the private insurance companies that process and pay Medicare claims. The FY 2001 President's Budget invests $48 million in a contractor oversight initiative to improve internal controls and financial management. We have also consolidated responsibility for contractor management by establishing the new position of Deputy Director for Medicare Contractor Management. And we have created a Medicare Contractor Oversight Board to set policy regarding contractor-related activities. As part of this effort, we also are working with the Inspector General's office to create individual report cards on each contractor's performance against specific goals and criteria. Contractors that perform poorly and fail to improve risk losing their Medicare business.

In addition, we are hiring additional physicians as claims processing contractor Medical Directors to improve the effectiveness of medical review and foster better understanding of program integrity issues with the provider community. We are making more efficient use of prepayment review with claims processing computer "edits" that automatically deny improper claims before payment is made. We are also evaluating local review policies to determine where national policy may be needed, and measuring how well individual contractors perform medical review activities.

We also have implemented a change management process to manage and coordinate changes to the Medicare fee-for-service program in a more timely and effective manner. This process is designed to allow our central and regional office staff, as well as our contractors, to participate cooperatively in each phase of the development and review process on Medicare Contractor manual issuances and program memoranda. It also ensures that we provide a single, consistent voice to our contractors.

In addition, we are requiring contractors to report to our regional offices quarterly on the implementation of Medicare instructions that directly impact providers, such as payment and coding changes. Our regional offices will work in consultation with the contractor to ensure that any implementation problems are quickly resolved. The regions also will track the timeliness of the contractors in addressing any needed changes on an ongoing basis, and will incorporate these findings into the annual contractor performance evaluation process.

Ensuring Program Integrity

We also are redoubling our efforts to identify fraud, waste, and abuse in all of our programs. Today, our efforts are more effective than ever before. From April-September, 1998, we stopped about $5.3 billion from being paid to providers for inappropriate claims. Our anti-fraud efforts returned nearly $500 million to the federal government, a 65 percent increase over the previous year. And we have reduced the Medicare error rate by almost half since 1996, and maintained that progress in 1999. The annual Medicare financial audit helps us to identify areas where we can be better stewards of the Medicare program. Each year it has led us, working in cooperation with Congress, providers, and contractors, to improve the integrity of our program, including our claims processing and payments.

We realize that our efforts to reduce fraud, waste, and abuse may have generated concern among some providers. Let me be clear. We have no intention of prosecuting anyone for honest

mistakes. If providers do make billing errors, we want to find those errors, preferably before we make payment. If we find errors after we make payment, make no mistake about it--we do want the money back.

However, we are not looking to put anyone in jail for honest mistakes, and we are not going to refer providers to law enforcement for occasional errors. We know that the majority of providers are honest and conscientious. Let me also be clear, however, that we have zero tolerance for fraud, waste, and abuse. Our goal is to receive accurate and properly documented claims from providers and to pay those claims correctly. That way beneficiaries, taxpayers, and providers can all be confident that our program is effectively managed, our tax dollars are appropriately spent, and our beneficiaries receive the quality, affordable care on which they depend.

Balanced Budget Refinement Act

Working together, Congress and the Administration, enacted the BBRA last year, which includes a number of payment reforms and other changes to address some of the BBA's unintended consequences. A number of these refinements will be particularly helpful to America's hospitals. These include:

- modifying the hospital outpatient prospective payment system (PPS);
- increasing indirect medical education payments to teaching hospitals;
- reducing the geographic disparity in direct medical education payments to teaching hospitals;
- increasing disproportionate share hospital payments;
- increasing payments for PPS-exempt hospitals; and
- improving rural hospital programs.

We also have taken a number of our own administrative actions to moderate the impact of the BBA. These steps complement the legislative changes included in the BBRA and will help hospitals and other providers in meeting the needs of the patients they serve. For example, we are postponing expansion of the BBA's "transfer policy" for all hospitals for a period of two years, through 2002. As a result, the transfer payment limits will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.

The BBA created a new PPS for hospital outpatient care that pays set amounts for services that are similar clinically and in their use of resources. Responding to the concerns expressed by providers, the BBRA modifies the outpatient PPS in several important ways. It smoothes the transition to the new system, during the first three and a half years, by creating payment floors, holding small rural hospitals with fewer than 100 beds harmless for three and one-half years and cancer hospitals permanently harmless. During the transition period, we are protecting hospitals by paying a part of any reduced payments they might incur, under the new system, for outpatient services. In addition, this new system makes additional payments to hospitals for certain new medical devices and drugs, and it establishes an outlier payment policy for high-cost cases.

The BBRA makes important investments in our nation's graduate medical education (GME) programs by increasing Indirect Medical Education payments and reforming Direct Medical Education. It reduces the geographic disparity in payments to teaching hospitals; raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average; and limits growth in payments for hospitals being paid more than 140 percent of the geographically adjusted average.

The BBRA also increases Medicare disproportionate share hospital payments, makes adjustments to the PPS system for inpatient rehabilitation hospitals, and requires the development of PPS systems for long-term care and psychiatric hospitals. And it enhances a series of Medicare policies designed to support rural hospitals. For example, it allows certain rural hospitals to reclassify as Critical Access Hospitals, Sole Community Hospitals, or Rural Referral Centers; extends the Medicare dependent hospital program for five years; provides exceptions to the residency caps for rural GME; and rebases targets for Sole Community Hospitals and provides them with a full increase for inflation in 2001.

Using our administrative authority, we are building on the BBRA changes to further assist rural hospitals. For example, we are making it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. This change will be included in the inpatient PPS regulation that will be published shortly. As a consequence of this change, these rural hospitals will receive higher reimbursement. Similarly, we are helping rural hospitals adjust to the new outpatient PPS by using the same wage index for determining a facility's outpatient payment rates that is used to calculate its inpatient rates.

We will continue to closely monitor how laws and regulations governing our programs affect beneficiaries and providers. We want to hear from you about problems that Medicare providers and beneficiaries may be having. And we will continue to examine our own regulations and policies to make adjustments where we can under the law to ensure that beneficiaries continue to have access to the quality care they deserve.

Conclusion

Ensuring that beneficiaries have access to quality health care is a priority for our Agency. We are increasing our efforts to educate hospitals and other providers about Medicare policies. And we are working closely with our fiscal intermediaries to ensure they have the information, tools, and training they need to process and pay claims appropriately and that their guidance to providers is clear. Together, we can minimize honest errors, and prevent fraud, waste, and abuse in the Medicare program. Through administrative actions, we have been working to moderate the impact of the BBA where we can. We are implementing the numerous changes contained in the BBRA that directly impact hospitals and other providers. We welcome your input and assistance as these efforts move forward, and we appreciate your continued interest. I am happy to answer your questions.

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